

Improving Access to Care for Traumatized Children: Law Enforcement–Mental Health Collaborations for Child Witnesses to Violence

by Abigail Gewirtz, Donald Harris, and Mary Jo Avendano

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The majority of children involved in violent events are witnesses who suffer psychological, rather than physical, harm. The presence of these children may go undetected by social service providers unless police need to interview them as part of their investigation, as shown in this photo illustration.

Following a police raid on a residence in which both adults had outstanding warrants for drug and assault charges, the Minneapolis Police Department paged an on-call psychologist to the home. Four young children had witnessed significant violence and, subsequently, a police raid and arrests. When the psychologist arrived, she found all four children crying hysterically. She spent time with each of the children, helping to calm them down by teaching them ways to control their breathing. Meanwhile, the officers made calls to child protective services and to the children's relatives in an attempt to

have the children placed together with kin. When it was clear that this would not be possible, the officers prepared to take them to a temporary foster placement. Together, the clinician and the officers (who had received training in trauma and child development) explained to the children what was going to happen to them. The clinician helped prepare the children to leave the home, and each child was allowed to take a loved blanket or toy. Before they left the home, they were given time to say goodbye to their father, who was being taken to jail. The officers left the clinician's contact information with the foster home.

Subsequently, the officers kept the clinician informed regarding the parents' criminal case, and the clinician was able to communicate this information to the children.

Each year, an estimated 3.3 to 10 million children are witnesses to and victims of violence in the home. In one study of children living in low-income neighborhoods, 75% reported having witnessed community violence. Children exposed to violence are at heightened risk for behavioral and emotional problems, as well as social and interpersonal difficulties. The link between early exposure

to violence and later perpetration or victimization has been well established. A study by Cathy Widom and Michael Maxfield reported in the February 2001 National Institute of Justice's *Research in Brief* found that children exposed to violence or abuse were 59% more likely to be arrested as juveniles, 28% more likely to be arrested in adulthood, and 30% more likely to be arrested for a violent crime. Moreover, children's exposure to violence overlaps with exposure to other types of risk factors. For example, studies have revealed that an estimated 30% to 60% of children who witness domestic violence are also victims of child maltreatment. Although domestic violence occurs at all levels of society, its consequences may be more significant at lower income levels, where limited economic resources limit women's choices in fleeing abusive relationships.¹ Among low-income families, domestic violence is also associated with homelessness. Significant numbers of mothers in homeless shelters cite domestic violence as one of the primary reasons for shelter residence. In addition, as Abigail Gewirtz and Resmaa Menakem note in their January 2004 report *Working with Young Children and Their Families*, locally the average income of women in domestic violence shelters is below the poverty level. Children exposed to violence are also more likely than other children to be exposed to adult substance abuse. Community violence is associated with living in high-crime, inner-city neighborhoods, with less community and social service infrastructure. A growing literature has documented the co-occurrence of children's exposure to domestic and community violence.

Although children may be victims of violence or abuse, the majority of children involved in violent events are witnesses who suffer psychological, rather than physical, harm and thus are less likely to come to the attention of service providers. These children have been described as the "silent victims" of violence. As our introductory example illustrates, strategic cross-disciplinary partnerships can result in the effective provision of timely, developmentally and culturally appropriate care for children in the aftermath of acutely traumatic circumstances. In this article, we outline the barriers to the identification of child witnesses to violence, providing

a rationale for the development of interdisciplinary community collaborations to increase access to care for such children. We then review and report data from one such local collaborative model aimed at increasing access to care for children exposed to violence. This model, the Child Development Policing Program, is a project of the Minnesota Child Response Initiative,² a multi-agency, multi-system collaborative aimed at increasing access to effective, timely, and appropriate services for traumatized children and their families. The research on which this article is based was supported in part through a grant from CURA's Communiiversity program in 2003, which facilitated early work on the development of a series of community needs assessments and geographic mapping of resources in the Twin Cities metropolitan area for children exposed to violence. Since then, the initiative has received foundation, individual, federal, state, and local funding.

Identifying Child Witnesses to Violence

In 2005, the President's New Freedom Commission on Mental Health acknowledged children's witnessing of violence as a growing public health problem, but no national or local surveillance system tracks children's exposure to violence. In contrast, well-developed surveillance systems track other potential stressors in children's lives—for example, child abuse and neglect, accidental injuries, and family/caregiver status. A primary reason for the lack of a surveillance system includes the difficulty identifying child witnesses to violence in the absence of physical injury to the child. For example, most domestic violence goes unreported, and when incidents of violence are reported to police or paramedics, physically unharmed child witnesses—especially young children—often are ignored because they have no role in a police investigation or because their status does not meet statutory child protective services reporting requirements for child maltreatment. Similarly, when incidents of community violence such as shootings are reported, the presence of the children who may have witnessed the event or its aftermath may go

² The Minnesota Child Response Initiative, now known as the Minnesota Child Response Center, is a broad-based collaboration of child-serving agencies and systems in the Twin Cities metropolitan area. For more information on the project, including a full list of partners, visit www.childresponse.org.

undetected unless police need to interview these children as part of their investigation. Fear of the abuser or the legal system, shame, or worry about potential child protection involvement may deter parents from seeking help on behalf of their children.

Identification of child witnesses to violence is a necessary prerequisite to understanding the scope of the problem and potentially useful prevention or intervention strategies, but the means for identifying such children has been contentious and oft-debated. Several states, including Minnesota, have created statutes mandating the reporting of children's exposure to domestic violence under child maltreatment criteria. The unintended consequences of such statutes, however, include placing a tremendous burden on already overwhelmed child protection departments, as well as the intrusion of government into the lives of families where non-offending parents may be making strenuous efforts to keep their children safe. For example, in 1999, the Minnesota state legislature amended the definition of child neglect to include domestic violence "within sight or sound of the child." As Jeffrey Edleson documented in a chapter on childhood exposure to domestic violence in the 2004 book *Protecting Children from Domestic Violence: Strategies for Community Intervention*, the unintended consequences of this statute included an estimated cost of \$30 million per year to counties to implement the statute, as well as 50–100% increases in child protection reports for children's exposure to adult domestic violence, across Minnesota counties. The statute was withdrawn in the 2000 legislative session. Clearly, tracking children's exposure to violence not only presents a technical challenge, but also raises ethical and risk dilemmas that must be addressed. Some states (e.g., Alaska) have addressed the complex nature of the identification and tracking of children's exposure to violence. These states have incorporated the level of risk to which a child is exposed and the severity of violence as criteria by which to consider the state's intervention/investigation through child maltreatment reporting criteria.

Rationale for Interdisciplinary Models of Collaboration to Address Children's Exposure to Violence

Child witnesses to violence may appear at the entry points of several governmental and social service systems, including child protection, juvenile

¹ Research indicates that the vast majority of domestic violence victims are adult women.

justice, mental health, and law enforcement or court systems. Often, children who have histories of chronic exposure to violence are identified after-the-fact when, for example, behavioral problems that occur after trauma exposure result in juvenile justice, child welfare, or other system interventions, including mandates to attend mental health treatment. Prevention and intervention research data point to the importance of early intervention and prevention for high-risk children and families, and demonstrate that cognitive behavioral treatment approaches are the most consistently effective approaches to early intervention (i.e., intervention that occurs weeks to months after a traumatic event).³ However, the barriers to locating and identifying children who witness violence present difficulties to offering very early intervention for these children.

Precisely because children's witnessing of violence is underreported and goes unidentified, locating and developing partnerships with key identification "entry points" is a prerequisite to increasing access to voluntary mental health and prevention services for traumatized children. One such key entry point is law enforcement: As the first responders to reported incidents of violence, police represent an important potential gateway to services for traumatized children. The tasks of police officers on the scene of a violent crime are threefold: securing the scene (i.e., ensuring the safety or access to medical services of victims, witnesses, or bystanders), apprehending alleged perpetrators, and opening the criminal investigation. Their role as first responders often precludes police officers from focusing on providing psychological support or advocacy services; nonetheless, like other frontline providers such as general medical practitioners, police officers can be key referral gateways for the families they protect and serve.

During the past 15 years, interdisciplinary models of collaboration to benefit children have emerged, partly in response to the increased recognition of the drawbacks of single-system or categorical funding responses. One

successful example is the development of systems-of-care approaches in children's mental health, which recognize the multiple systems serving children with mental health needs and encourage a collaborative or "wrap-around" approach to services, characterized by blending funding from several sources to provide the child with the necessary services rather than just the services that specific funding streams allow for. Similar models have been proposed in the area of children's exposure to violence resulting, in part, from the federal Children Exposed to Violence initiative launched in the mid-1990s and the U.S. Department of Justice's Safe Start Initiative. Models of police-mental health collaboration exist in pockets throughout the country, notably Yale's Child Development Community Policing Program, the Child Witness to Violence Program at Boston Medical Center, and the New Orleans Victim Intervention Program. The common goals of all these programs include increasing access to crisis and treatment services for traumatized children and training police officers to be aware of the needs of children they encounter in the course of duty. These models recognize the important influence of police on the lives of children—particularly children exposed to violence and trauma—and the pivotal role that officers play in the immediate aftermath of traumatic incidents.

The Child Development Policing Program

Locally during the past three years, the Minneapolis Police Department and community and university partners have been working together to develop and sustain a police-mental health collaboration. The purpose of this collaboration is to increase access to services for children who are traumatized and ultimately to ameliorate the impact of violence on children. Below, we outline initial findings from this early intervention model, called the Child Development Policing Program (CDPP). The program—which is voluntary for families—partners police officers, children's mental health providers (psychologists and clinical social workers), and family advocates to enhance police officers' skills when encountering children, particularly those traumatized by violence, and to provide clinical intervention in the close aftermath of violent incidents witnessed by children.

The program offers a 24 hours per day, 7 days a week, on-call pager service, and has also provided a squad car three evenings a week to facilitate early intervention and follow-up visits for children traumatized by violence. The patrol officers who first respond to the scene of the violent incident offer families program services. Usually officers introduce the program by telling the caregiver: "We have a program to help kids who've been exposed to violence. There is a counselor who is available to meet with you and your kids and offer some resources to help. Would you like me to call them?" Once introduced (either by phone or in person, depending upon the wishes of the caregiver), the clinician and the caregiver decide together whether an immediate meeting is indicated or whether (particularly late at night, with very young children) the clinician should meet with child(ren) and parent(s) the following day. The goals for early intervention are (1) to offer immediate assessment and crisis trauma services to children (e.g., normalizing children's fears, and decreasing anxiety through the teaching of behavioral strategies and coping skills), (2) to make appropriate referrals for further services for children and their family, and (3) to provide psycho-education for parents regarding the impact of exposure to violence on children. This model of trauma intervention has a cognitive-behavioral focus that aims to address the distorted thoughts, feelings, and behaviors that may follow exposure to a traumatic event, presenting barriers to recovery and adjustment. Clinicians provide crisis assessment and acute trauma-focused intervention for the child(ren), whereas CDPP advocates work with the mother/caregiver to address immediate needs, such as shelter and safety planning, and to provide a 911 cell phone where needed.

In situations where officers and clinicians are present together, the officer discusses safety and legal issues with the victim or caregiver. A pamphlet with information about children's exposure to violence and program contact information is left with the family. Service referrals offered to the family may include legal advocacy, outpatient mental health services, parent-child programs, mentoring or "buddy programs," after-school programs, and assistance with

³ Raul R. Silva, Marylene Cloitre, Lori Davis, Jill Levitt, Sandy Gomez, Irene Ngai, and Elissa Brown. Winter 2003. Early intervention with traumatized children. *Psychiatric Quarterly* 74 (4): 333-347; D.S. Pine and J.A. Cohen 2002. Trauma in children and adolescents: Risk and treatment of psychiatric sequelae. *Biological Psychiatry* 51 (7): 519-531.



Police training is a critical component of the Child Development Policing Program. The goal is to train officers and supervisors to be aware of their impact on children at the crime scene and to develop skills in sensitive interactions with children. At present, nearly 800 police officers have participated, representing all ranks of the Minneapolis Police Department.

housing. During the days and weeks following the visit, one member of the team follows up with the family by phone (and, where requested, in person) to facilitate the referral process and to support the family to engage in needed services. The CDP program is voluntary, but team members are careful to describe their mandated child protection reporting responsibilities to families at the outset of the encounter.

Police training is also a critical component of the CDPP. The goal is to train police officers and supervisors to be aware of their impact on children at the crime scene and to develop skills in sensitive interactions with children. Training is achieved through mandatory in-service presentations of one to three hours in duration, focusing on the impact of violence on children's functioning and how to interact with children in the immediate aftermath of a violent event. At present, nearly 800 police officers have participated, representing all ranks

of the Minneapolis Police Department. An advanced training program has been piloted with 15 supervisory officers, incorporating an 18-hour curriculum developed to provide more intensive training in trauma, child development, and policing.

Program Findings—Children and Incident Characteristics

Below we report descriptive data from a records review of 507 families with 1,012 children who were referred to the CDPP between the summers of 2003 and 2005. Program clinical records are stored in a secure, computerized database in which clinicians document case details and services provided to the family, including follow-up contacts. We received University of Minnesota Institutional Review Board approval to analyze the records. The 507 case records we reviewed represented 85% of the total number of unique families referred for services during that period and all of the families referred to the program

following incidents of domestic violence. The other 15% included children exposed to community violence and high-risk warrants/drug raids.

Prior incidents of domestic violence in the home or experienced by the victim were noted in the database, based on victim or police report. Prior domestic violence was indicated in 69.3% of the cases. Despite the relatively high incidence of prior violence, records indicated that only 33.5% of families had ever participated in any kind of social services.⁴

Incidents of domestic violence varied widely in nature and severity and included verbal abuse (67.7% of cases), physical abuse (82.6% of cases), and/or property damage (24.1% of cases). In this sample, 85% of cases were charged by police as misdemeanor level offenses and 15% were reported

⁴ Data on service history and substance abuse as an element in the incident were only available for 187 families—those who spent a longer time with the CDPP team and about whom more information was available.

as felonies, representative of the misdemeanor/felony breakdown of the total number of domestic violence cases in Minneapolis.⁵ A weapon was used in 15.3% of cases. Substance abuse was an element in 87.5% of cases (substance abuse was considered an element of the violence when reported to the police as a causal factor in the incident or when police discovered either the perpetrator or the victim to be intoxicated).

Age data were available for 874 children, of whom 445 (50.9%) were girls and 429 (49.1%) were boys. Children's ages ranged from infancy to 18, but the mean age was 7, with girls significantly older than boys (mean age of 7.94 years and 7.03, respectively). The mean number of children per household was two. A little more than half of the children (55%) were the biological offspring of both the victim and the perpetrator; an additional 26.1% were the biological children of the victim only, and 1.9% of children were the offspring of just the perpetrator.

Children's proximity to the violent incident was assessed based on documentation in the police report or by the report of the adults present. Children were classified as being not present (i.e., out of the house during the incident), indirectly exposed (i.e., in another room in the apartment or house; able to hear but not see the violence), direct witnesses (i.e., able to see and hear the violence and/or in the same room in the house), or directly physically involved (e.g., called 911, held by parents during the violence, attempted to break up the violence). As noted in Figure 1, two-thirds of the children for whom data were available (635 children) were direct witnesses or directly physically involved in the incident, with the remaining one-third not present or indirectly exposed.

Data on children's proximity to the incident were combined with child age data to understand how proximity to the violent event might differ by age. As Figure 2 indicates, the results of our analysis showed a significant positive relationship between age and proximity; that is, older children were significantly more likely to be closer to or more involved in the violent event.

⁵ On average, the Minneapolis Police Department receives 18,000 calls for service each year for domestic incidents. Approximately 6,000 incidents each year are formally written up and charged as domestic violence, the majority of them as misdemeanor offenses. About 800 of these (13%) are investigated as felony offenses.

Figure 1. Children's Physical Proximity to Incidents of Domestic Violence (number of children = 635)

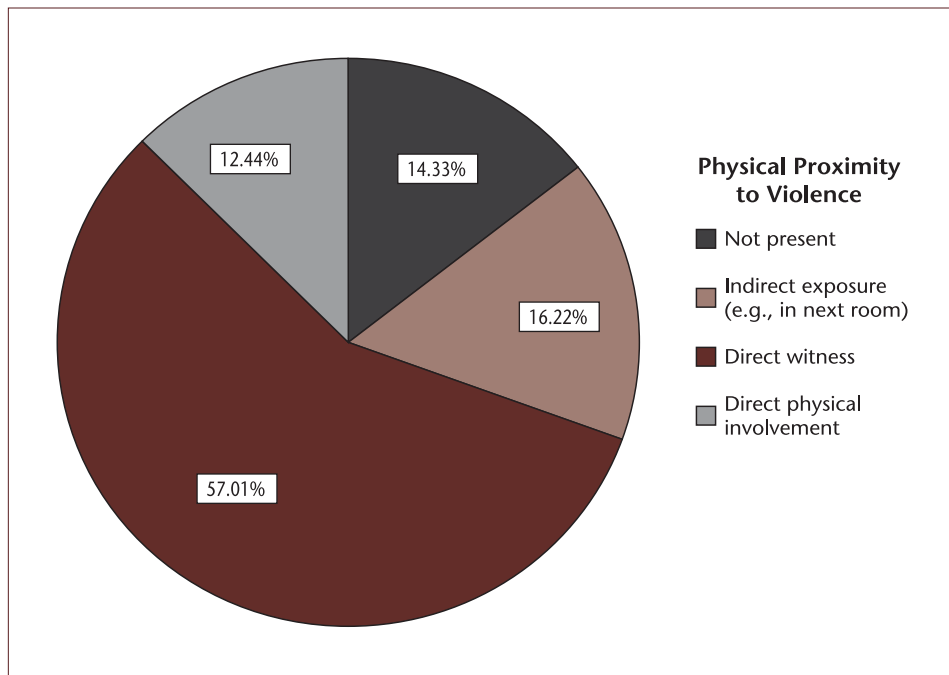
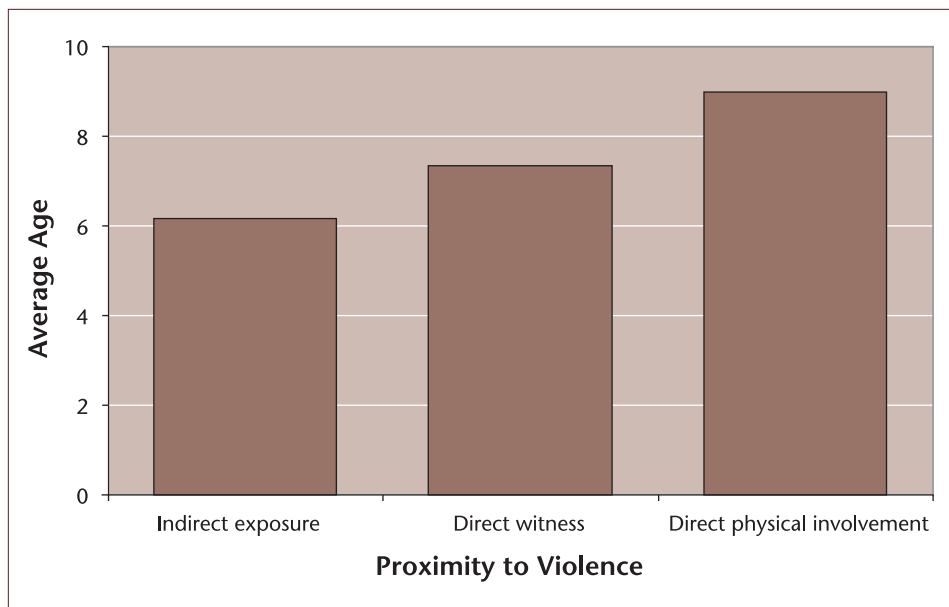


Figure 2. Children's Physical Proximity* to Incidents of Domestic Violence by Average Age (number of children = 635)



* The category "Not present" is not included in this graph.

Conclusions

The results of this study indicate that families served by this program were exposed to a variety of stressors associated with domestic violence. A high proportion of cases involved substance abuse, the majority of families had prior experiences of domestic violence, and yet only one-third of families had ever engaged in social services.

Consistent with prior studies, the child witnesses to violence identified

by this program were young, and the vast majority of them were at home during the violent incident, mostly in the same room or able to see and hear the violence. Furthermore, children's involvement or proximity was associated strongly with age, such that older children were significantly more likely to be directly physically involved in the violent incident than younger children.

Although the empirical focus for this article was information gathered

from children and families, the significant numbers of families referred by police to the program, and the extensive training of police officers, suggests that this program has been successful in partnering police officers and clinicians to raise awareness of the needs of traumatized children and to increase their access to services. In addition, the fact that more than two-thirds of families referred to the program had *never* previously sought or received services despite significant prior exposure to domestic violence suggests that this program was successful in reaching out to underserved families.

Although systems historically have attempted to solve social problems from a single-system vantage point, addressing complex social problems requires a multidisciplinary perspective. The increase in comprehensive community approaches to address domestic violence is one example. Such an approach might encompass changes in prosecution policy, policing and probation approaches, and child protection practices, but the key to such an approach is the ability of each system to partner with others. In a study published in the April 2006 issue of the journal *Violence and Victims*, Abigail Gewirtz and colleagues documented a successful example of such an approach to the prosecution of domestic violence cases involving children by the Ramsey County Attorney Office's Joint Prosecution Unit. Other examples of partnership strategies include community probation officers with police radios who can immediately inform law enforcement of the presence in the community of a defendant for whom a warrant is outstanding; child protection workers partnering with battered women's advocates to enhance practice with children and mothers exposed to domestic violence; and the co-location of city prosecutors in police precincts creating a "one-stop shop" for crime victims.

In the CDPP, police officers partner with mental health professionals to enhance access to care for children traumatized by violence and to lessen the impact of exposure to violence by providing on-site early intervention, assessment, and referral. Training provides police officers with enhanced skills in communicating with children and in understanding through the eyes of children the impact on children of exposure to violence. Officers learn, for example, that an average four-year-old child stands at the eye height of

a police officer's gun and utility belt. The simple act of bending down to the child's level gives the child a different view of police! Having mental health professionals on call 24 hours a day and seven days a week enables officers to access specialized psychological help, just as they might access other specialized services such as interpreters, medical help, or legal services.

Families have reported relief and surprise that police, typically known as responsible for enforcing the law and providing physical protection, can also access services that enhance children's and families' psychological safety and coping. Families have reported particularly appreciating that clinicians will come to them; many families are too overwhelmed and overburdened with physical tasks in the aftermath of violence (physical injuries, legal issues, school and work) to attend to psychological needs. Mental health professionals leave their clinics to provide timely, on-site services that, it is hoped, will lessen the risk of children displaying unidentified and untreated trauma symptoms for a long period of time.

Not all families welcome intervention offered by or through a law enforcement officer, however. In communities where members have often been targets of police apprehension or discrimination, or for whom a police presence is shameful or a threat, police officers may be viewed with suspicion and distrust. In this program, clinicians and advocates have the flexibility to provide the services that the family needs, in the location the family desires, with or without a police presence. However, given that police officers are the portal for services, families exposed to violence that do not seek police or social services do not have access to this model of early intervention for their children.

Based on lessons learned to date, the key benefits of this program appear to be the increased opportunities it offers for traumatized children to receive early intervention crisis and referral services, for parents to have access to information about children's exposure to violence, and for police officers to increase knowledge and skills in dealing with traumatized children and child development. The following recommendations are based on program findings and experience in this cross-disciplinary collaboration to benefit children and families exposed to violence:

1. Although cross-disciplinary partnerships are inherently logical and desirable, they take time and resources to develop and sustain. Categorical funding, as well as practices and policies that limit communication and information-sharing across systems, provide just a few of the incentives for individual service systems not to collaborate and to actively deter others from crossing disciplinary lines. Government leadership, policies, and funding mechanisms can provide concrete incentives for true collaborations (e.g., flexible funding, dissemination of demonstration models, standards for collaboration) and should demand significant evidence for meaningful partnerships.
2. Increasing first responders' (in this case, police) knowledge, awareness, and skills with respect to children's needs, particularly in the aftermath of traumatic events, is key to increasing identification of traumatized children and maximizing the positive impact of police officers in promoting resilience in the lives of our youngest citizens. Akin to training doctors in bedside manner, training police officers (and other first responders, such as firefighters and emergency medical technicians) to better communicate with children should be an integral part of academy and in-service training.
3. Partnering police and mental health providers provides a logical first step in the development of a comprehensive continuum of care for traumatized children and youth, in the same way that schools and medical providers often collaborate to identify and serve high-risk children. Several federal initiatives (e.g., National Child Traumatic Stress Network, U.S. Department of Justice's Safe Start Initiative) have recognized the value of such partnerships, and are funding demonstration projects across the country to implement them, but these models could be disseminated more broadly at the state and local levels.
4. Very little research documents the details of children's experiences in domestic violence incidents or investigates children's functioning in the acute aftermath of these incidents. Although the program data we evaluated revealed valuable information about children's presence during violent incidents, following families over time to gauge program effects is

more complicated and costly.⁶ Grant funding often is focused on delivery of services, program dissemination, or training and technical assistance at the expense of thorough program evaluation. However, such evaluation is critically needed to determine and highlight program effects.

Several challenges remain in meeting the needs of vulnerable, traumatized children and their families. Given the significant public health problem posed by children's exposure to violence, however, the investment in finding ways to promote children's health and resilience seems well worthwhile.

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⁶ We have recently developed an anonymous, automated telephone survey, available in English and Spanish, to begin to gauge program effects in a minimally intrusive way. Families who participate in the CDPP acute intervention are given a brochure about children's exposure to violence, and, with it, a slip of paper inviting them to participate in a 5–7 minute telephone survey. Families call a local phone number to participate in the automated survey and are reimbursed with a small thank-you gift certificate if they provide a mailing address.

professor at the University of Minnesota, where she teaches and conducts research at the Institute of Child Development and in the Department of Psychology. She was formerly director of operations for the National Center for Children Exposed to Violence at Yale University's Child Study Center. Her research focuses on resilience, risk, and protective factors for children exposed to domestic violence, homelessness, and related traumatic stressors; and on the development of effective family-based preventive interventions that promote resilience among these children. **Donald Harris** is deputy chief of the Minneapolis Police Department. **Mary Jo Avendano, Psy.D., LMFT**, is clinical supervisor of the Child Development Policing Program and clinical director of Centro Cultural Chicano, a large social services agency providing comprehensive social and psychological services to the Latino community. Her professional experience includes clinical positions at community and county agencies, including Tubman Family Alliance and Hennepin County Children's Mental Health. Originally from Colombia, South America, Dr. Avendano has extensive expertise working with diverse Latino

children, adults, and families, particularly those facing trauma and hardship.

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Project Funding Available from CURA

The Center for Urban and Regional Affairs supports community-based research projects through several different programs. If you represent a community organization or agency and are unsure which program listed below is most suitable for your project proposal, simply complete a general Community Program Application Form at www.cura.umn.edu/Programs/curaappform.html and we will route your request to the appropriate program.

■ **The Communiversy Program** funds quarter-time graduate student assistantships for one semester to help community-based nonprofit organizations or government agencies with a specific project. The application deadline for fall semester 2006 assistantships is June 30, 2006. For more information, contact CURA community program coordinator Jeff Corn at 612-625-0744 or curacrbr@umn.edu.

■ **The Community Assistantship Program (CAP)** matches community-based nonprofit organizations, citizen groups, and government agencies in

Greater Minnesota with students who can provide research assistance. Eligible organizations define a research project, submit an application, and if accepted, are matched with a qualified student to carry out the research. The deadline for applications for fall 2006 support (September to January) is June 30, 2006. For more information, to discuss potential projects, or for assistance with applications, visit www.cura.umn.edu/cap.php or contact CAP coordinator Will Craig at 612-625-3321 or capcura@umn.edu.

■ **Neighborhood Planning for Community Revitalization (NPCR)** provides student research assistance to community organizations in Minneapolis, St. Paul, and metro area suburbs that are involved in community-based revitalization. Projects may include any issue relevant to a neighborhood's or community's needs and interests, including planning, program development, or program evaluation. Priority is given to projects that support and involve residents of color. Applications from organizations collaborating on a project are encour-

aged. Applications for fall 2006 support (September through January) are due June 30, 2006. For more information, visit www.cura.umn.edu/npcr.php or contact NPCR program director Kris Nelson at 612-625-1020 or ksn@umn.edu.

■ **The New Initiative** program accepts project proposals from community organizations, government agencies, and University of Minnesota faculty and students for projects that are inappropriate for or unrelated to other CURA programs. CURA is always looking for a good new idea, and supports many new projects outside of our existing program areas. The best approach is to call us to discuss the idea; if it looks worthwhile, we will encourage you to write a brief proposal. For projects supporting government agencies, we usually seek matching funds. Maximum support for a project is generally a half-time graduate student research assistant for one academic year; support for one semester is more typical. For more information or to discuss a project idea, contact CURA associate director Will Craig at 612-625-3321 or wrcraig@umn.edu.